illiterate profession, but more a reflection of the complexity of the problem. The fact that past treatments were successful does not provide evidence regarding why or how the treatment favorably affected the symptoms.

As health care providers, we must appreciate that our main professional duty is to reduce the suffering of our fellow men and women. We are obligated to do this with the overriding principle of “do no harm.” Therefore, our treatment choices must be based on scientific evidence. In the absence of evidence, we are obligated to provide the most conservative approach possible. The AADR statement is merely reminding us of this obligation. If we think that different or more aggressive treatments are indicated, it is our obligation to demonstrate the evidence that supports such direction. Until that time, we need to select treatments for our patients with the overriding premise of “do no harm.”

On the surface, one would assume that diagnostic instruments do not harm. They certainly do not harm the patient when they are used to collect data. However, if the data derived from these instruments lead the clinician to incorrectly diagnose an orofacial pain problem or to select inappropriate treatment, then harm can be done. It is logical to assume that instruments that provide more data and perhaps more measurability should be helpful in diagnosing and selecting treatment. However, the validity, reliability, specificity, and sensitivity of these instruments must be demonstrated before data can have meaning.

Some clinicians are upset with the AADR position statement. Perhaps this is because it does not align with their own personal experiences and clinical opinions. I suggest that instead of being upset, we use this opportunity to motivate us to research more and better ways of managing TMDs. The overriding concept is that this must be done in the best interest of our patients and must be founded on evidence-based science.

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New technologies on TMJ diagnosis

To the Editor:

I have recently read an article in OOOOE (August, 2010), “Diagnosis and treatment of temporomandibular disorders: emergence of a new care guidelines statement,” with special attention to the paragraph affirming that electronic diagnostic devices, such as electromyography, jaw movement trackers, and sound recorders have failed to meet standards of reliability and validity, not satisfying the requirements for sensitivity and specificity that are essential for clinical diagnosis of individual patients.

I have been using these technical devices (Myotronics system) since 1995 in Brazil, gathering >9,000 examinations since then. The editorial alerts us to the true need for a new guideline statement, but it jumps to a mistaken conclusion when affirming that this equipment fails in reliability and validity. These technologies are extremely accurate in giving detailed information on biometry, and the reliability of the data is above any doubt or questioning. Actually, the equipment’s role is to give us information about the patient, and this goal is a clear achieved. It is our (professional) role to establish the relationship between the data given by the system and temporomandibular joint (TMJ) pathology. The writers of the article failed in establishing the technology–TMJ disorder connection, and that is far from meaning that the technology is not reliable.

This connection is a long journey, and we have already gone a long way working hard (40 years of surveys and published papers all over the world) to establish secure and clear relationships between TMJ disorders and electronic device data in several clinical situations. For example, it is now inadequate to undertake surgical procedures such as orthognatic and TMJ surgery without deep analyses of patient muscular, jaw tracking, and sound information. I remind you that this same technological confusion has happened in the past with other diagnostic technologies that have improved afterward to be trustworthy become very useful in medicine. Denying this shows, at least, disrespect and inconsideration to several serious scientists.

Please keep in mind that America is the “cradle” of medicine technology development, and the editorial makes an apologia of discrediting an important tool for diagnosis, leading TMJ science to a slow-motion pattern of development. You must realize the important place of OOOOE and the responsibility attached to the position of Chief Editor. Only God is omniscient, but we humans must have “omniscient behavior,” keeping our minds open to new achievements of the future.

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One has to wonder . . .

To the Editor:

One has to wonder . . .

Why Dr. Greene has chosen to try to prevent the practice of neuromuscular dentistry (NMD). Could it be that he is motivated by the same concern for protecting
the classic practice of orthodontics as has been taught for the past several decades, emphasizing straight teeth with little regard given to the final mandibular position created in relation to the base of the skull, often resulting in a retruded mandible? The same rationale applies, by the way, to the rules implemented by the Royal College of Dental Surgeons (RCDS) of Ontario, which is overrun with orthodontists and vehemently opposed to any technique encouraging mandibular advancement procedures. Apparently only mandibular retrusion is acceptable. There is no reason for this in science or logic. There has never been.

Why he quotes the efforts of the RCDS and Dr. Mohl, when they have been completely discredited and sanctioned by the Ontario public court system and the U.S. Food and Drug Administration, respectively, for pursuing their vendetta against NMD without scientific validity. The RCDS has since softened their stance against the practice of NMD in Ontario, a fact neglected in Dr. Greene’s diatribe.

Why no dentist trained in NMD has ever abandoned NMD. I’ve made this simple statement over the past 15 years in front of audiences all over the world, numbering in the thousands. Never once has it been challenged. How powerful must this philosophy be? The same cannot be said for any other philosophy, as I personally know dentists who have abandoned all other approaches. We all do.

Why the superior belly of the lateral pterygoid pulls forward. If indeed the condyle is supposed to be back and up, or forward and up, or just straight up, why did Mother Nature attach a muscle directly to the head of the condyle that pulls it forward? Centric relation is not supported in the literature or in logic. If it were correct, the TMJ would be the only joint in the body that operates physiologically at an extreme position. No joint does.

It’s time to reflect upon that time in dental school when you thought you knew some things, to find out years later that what you thought you knew (based on selected scientific studies) was wrong (e.g., dentin bonding). Thinking you know something is truly the greatest deterrent to learning, and it is a point Dr. Greene has yet to arrive at. He arrogantly believes that his approach is correct, by paying attention to selected scientific studies and ignoring not only the majority of those very studies, but also logic and Mother Nature at the same time. He suffers from the same delusion as most dentists ignorant of the true value of NMD. It is not about the money, it is about patient care. Allowing someone to suffer for years, when a solution exists, is not only malpractice, but ethically unforgivable. What if Dr. Greene’s wife were suffering every day, unable to eat properly, unresponsive to splint therapy and pharma-